WESTERVILLE PEDIATRIC SPECIALISTS, INC.

Parent/Guardian Name: _____M.I._____ Relationship:_____

Mailing Address: _____

City: _____State: _____Zip: _____ Date of Birth: _____ SSN#:_____

Cell Phone:_____ Home Phone: _____ _____Work Phone:_____

Email Address: _____ Employer: _____

Parent/Guardian Name: _____M.I._____ Relationship:_____

MailingAddress:_____

City: _____State: _____Zip: _____ Date of Birth: _____ SSN#:_____

Cell Phone:_____ Home Phone: _____ _____ Work Phone:_____

Email Address: _____ Employer: _____

****I give permission for the office to leave a message regarding my child's lab results, etc.**

(Please check one) Brief message_____ Detailed message_____

Signature_____ (Please check) Cell_____ Home_____

PHARMACY Name, Address & Phone Number: _____

I give permission for my medical provider to access pharmacy information from the pharmaceutical clearing house: Yes No

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CHILDREN: **Please circle:**

Name: _____ M/F_____Date of Birth: _____

Name: _____ M/F _____ Date of Birth:_____

Name: _____ M/F ___ _Date of Birth: _____

Name: _____ M/F ___Date of Birth:_____

In order to assist us in meeting Meaningful Use Measures with the U.S. Government, please answer the following questions below regarding your children:

Race: (Please circle one) American Indian or Alaskan Asian Black or African American Native Hawaiian or Other Refuse to Report/Unreportable White

Ethnicity: (Please circle one) Hispanic or Latino Non-Hispanic or Latino Refuse to Report

Primary Language: (Please circle one) English Hearing Impaired Other _____

INSURANCE INFORMATION (Please present insurance card upon check-in)

1) Name of Insurance Company:_____

Name of who carries the insurance: :_____

Relationship to Patient: _____

SSN#:_____

2) Name of Insurance Company: _____

Name of who carries the insurance:_____

Relationship to Patient: _____

SSN#: _____

Assignment and Release

Payment and/or copayment is required at the time the service is rendered. I hereby authorize my insurance benefits be paid directly to the physician, and I authorize the physician to release any information required to process any claims. I acknowledge that I am financially responsible for any non-covered services. By my signature, I authorize the release of immunization records, daycare forms, and medical records to another healthcare provider or daycare/school.

Signature:_____Printed Name:_____Date:_____